



## HMO Schedule of Benefits for State of Kansas Employees

<b>PCP Selection Required?</b> Yes	<b>Referrals from PCP Required?</b> Yes
<b>State(s) of Issue:</b> Kansas	

<b>Covered Services</b>	<b>Cost to Member</b>
<b>Annual Plan Deductible</b>	None
<b>Coinsurance For All Eligible Expenses</b> (unless otherwise noted)	10% Coinsurance
<b>Total Coinsurance Maximum</b> (does not include Copayments)	\$1,000 Individual/\$2,000 Family
<b>Lifetime Benefit Maximum</b>	\$3,000,000
<b>Inpatient Services</b> Services include semi-private hospital room & board, physician and surgeon services, lab, x-ray and other facility and ancillary charges.	\$200 per Admission Copayment Plus 10% Coinsurance <i>Copayment does not apply to Coinsurance Maximum</i>
<b>Outpatient Surgery</b> (not performed and billed in Physician's Office)	\$100 Copayment Plus 10% Coinsurance <i>Copayment does not apply to Coinsurance Maximum</i>
<b>Major Diagnostic Testing</b> (includes but is not limited to PET Scans, MRI, CT Scans, Nuclear Cardiology Studies, Magnetic Resonance Angiography and Computerized Topography Angiography)	\$100 Copayment Plus 10% Coinsurance <i>Copayment does not apply to Coinsurance Maximum</i>
<b>Outpatient Services</b> (Not Listed Elsewhere)	10% Coinsurance
<b>Physician Care<sup>1</sup></b> § Primary Care Physician (PCP) Office Visit  § Specialist Office Visit  § Physician Hospital Visits	\$20 Copayment <i>Copayment does not apply to Coinsurance Maximum</i> \$30 Copayment <i>Copayment does not apply to Coinsurance Maximum</i> 10% Coinsurance
<b>Urgent Care</b>	\$30 Copayment per Urgent Care Visit 10% Coinsurance for other services <i>Copayment does not apply to Coinsurance Maximum</i>

Covered Services	Cost to Member
<b>Ambulance/Emergency Transportation</b> (Ground or Air)	10% Coinsurance
<b>Emergency Services</b> (Copayment waived if admitted)	\$75 Copayment Plus 10% Coinsurance <i>Copayment does not apply to Coinsurance Maximum</i>
<b>Home Health Care</b>	10% Coinsurance \$5,000 Limit per Member per Calendar Year
<b>Hospice Care</b>	10% Coinsurance \$7,500 Lifetime Benefit Maximum
<b>Rehabilitation Services</b> § Inpatient Facility Based	\$200 per Admission Copayment Plus 10% Coinsurance
§ Outpatient Facility Based	10% Coinsurance
§ Office Based (Limited to 30 visits per Calendar Year Benefit Maximum)	Copayment Plus 10% Coinsurance
<b>Durable Medical Equipment (DME), Prosthetic Devices and Orthopedic Devices</b>	10% Coinsurance <i>Limited to \$5,000 per Member per Calendar Year</i>
<b>Allergy Testing</b>	\$30 Copayment Plus 10% Coinsurance <i>Copayment does not apply to Coinsurance Maximum</i>
<b>Allergy Shots &amp; Allergy Antigen Administration</b> (desensitization/treatment) <sup>2</sup>	Office Visit Copayment Plus 10% Coinsurance <i>Copayment does not apply to Coinsurance Maximum</i>
<b>Infertility Treatment</b> (includes diagnosis and 3 attempts at artificial insemination per calendar year)	\$30 Copayment Plus 10% Coinsurance <i>Copayment does not apply to Coinsurance Maximum</i>
<b>Biologically Based Mental Health Conditions</b>	Benefits same as any other medical condition – See applicable benefit
<b>Mental Illness, Nervous &amp; Mental Disorders and Alcohol or Chemical Dependency Treatment</b>	<i>See Appendix A - Mental Health Services section for details</i>
<b>Immunization</b> (If combined with office visit please see Physician Care section)	No Member Responsibility
<b>Preventive Care Services</b>	<i>Limited to One per Calendar Year</i>
§ Annual Well Woman Exam <sup>2</sup>	Office Visit Copayment

Covered Services	Cost to Member
§ Well Man Care <sup>2</sup> - Annual Prostate Screening and Office Visit § Periodic Age Appropriate Physical Exam and Routine Health Screening (Must be provided by PCP)	Office Visit Copayment  \$20 Copayment <i>Copayment does not apply to Coinsurance Maximum</i>
<i>One routine physical exam covered in full per member per Calendar Year, then subject to applicable copayment. Please see Preventive Services in Section 5 of the Certificate of Coverage for more detail.</i>	
• Well Baby and Child Care (Must be provided by PCP)	\$20 Copayment <i>Copayment does not apply to Coinsurance Maximum</i>
§ Routine Screening Mammograms	No Member Responsibility
§ Routine Vision Exam	No Member Responsibility <i>Limited to 1 Routine Vision Exam per member per Calendar Year</i>
§ Dietician Consultation	\$30 Copayment <i>Copayment does not apply to Coinsurance Maximum</i>
§ Routine Hearing Exam (Hearing aids are NOT covered)	\$30 Copayment <i>Copayment does not apply Coinsurance Maximum</i>
§ Age Appropriate Bone Density Screening	No Member Responsibility
§ Age Appropriate Routine Colonoscopy Screening	No Member Responsibility <i>Limited to 1 per member per Lifetime</i>
§ All other Colonoscopies	See Outpatient Surgery

**Please Note:** Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Please consult your Membership Handbook and Certificate of Coverage for additional details concerning your coverage including exclusions and limitations. This summary is designed as a partial description of the plan being offered and in no way details all the benefits, limitations or exclusions of the plan.

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card.
2. If you receive this service from a Primary Care Physician (PCP), your PCP copayment will apply. If you receive these services from a Specialist, your Specialist copayment will apply.